S. No. 2
M—5-42
5-17-39
I X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 2 1945

Registration District No. 231

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5811

State File No. 17601

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Montgomery

(b) City or town Rural Montgomery Tu

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community Life near High Hill Mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. 2 miles west of High Hill Mo

(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charley Connor

3. (b) If veteran, name war

3. (c) Social Security No. 497-20-I241

4. Sex M 0

5. Color or race C

6. (a) Single, widowed, married, divorced S 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug 9 th 1925 (Month) (Day) (Year)

8. AGE: Years I9 Months 8 Days I8 If less than one day hr. min.

9. Birthplace High Hill Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Louis Connor
13. Birthplace High Hill Mo (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Lucy Collier
15. Birthplace Shamrock Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant Lucy Connor

(b) Address High Hill Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (Month) (Day) (Year)

(c) Place: burial or cremation Connor Cemetery

18. (a) Signature of funeral director C. W. Hopkins

(b) Address Montgomery City Mo

19. (a) 5/29/45 (Date received local registrar) (b) Mrs C. E. Vandover (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year I945 hour 5 minute a M.

21. I hereby certify that I ~~attended~~ viewed the deceased from 27-May, 1945 at 8:30 am, 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured & Crushed Skull, Occipital and Mastoid Region

Due to Below, Backwards & Upward of Ear, Right Side of Head

Due to Length of Injury 6 to 8 inches

Other conditions None

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 970

(b) Date of occurrence May 27 1945

(c) Where did injury occur? Montgomery City Montg. Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Mile Post 87 - Wabash RR - 3 mi. West Montgomery (Specify type of place)

(e) Means of injury A Train

23. Signature Clement W Kunz Dr. Coroner

Address Montgomery City Mo Date signed 5/29/45

1060

(Licensed Embalmer's Statement on Reverse Side)

JUN 22 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by on the 27 th of May 1945, Registered Apprentice No. working under my personal supervision.

Signed C. W. Hopkins

Licensed Embalmer No. I487

P. O. Address Montgomery City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-3-45
X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 231 Primary Registration District No. 5811 Registrar's No. 16

1. PLACE OF DEATH:

(a) County Montgomery

(b) City or town Rural Montgomery Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charley Connor

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race C

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug 9 1921
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 27
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to 169-8

Due to 20

Other conditions
(Include pregnancy within 3 months of death)

Duration

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Examination - Stomach - Fractured & Crushed

Major findings:
Of operations Skull in Region rt. ear upward & Backwards involving mastoid & occipital Bones
Of autopsy About 3 inches wide 1 1/2 inch Deep

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident while trespassing on Wabash R.R. property

(b) Date of occurrence 27 May 1945

(c) Where did injury occur? Mile Post 87 - Wabash Right Way West Montgomery City Twp. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on Wabash Property
(Specify type of place)

While at work? No (e) Means of injury Hit by train

23. Signature C. W. Lemmet D.A.S. (M. D. or other)

Address Date signed 7 June 45

SUPPLEMENTARY

17601